

NH Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery



BRIEF SUMMARY OF COMPREHENSIVE APPROACH AND PROGRESS

The Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery¹ (Commission) and the New Hampshire Department of Health and Human Services (NH DHHS) are working with multiple partners from the public and private sectors at both the community and state level, to implement a comprehensive approach to address the misuse of alcohol and other drugs in New Hampshire. The Commission and NH DHHS support only policies, practices and programs informed by evidence of effectiveness.

NH SYSTEM

The State of New Hampshire is in the midst of a lengthy and comprehensive transformation of its systems and services to address substance use disorders more effectively. This transformation is multi-faceted, multi-dimensional, and associated with and influenced by other state system changes. The priority populations, substance misuse behaviors counter measures and best practices were largely developed through the Commission's strategic planning process conducted in 2013 and disseminated in early 2014 in the publication *Collective Action-Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery*.

This evidence informed plan utilizes clear logic to inform a comprehensive public health approach to address the misuse of alcohol and other drugs in New Hampshire. Elements of this comprehensive approach include population level prevention strategies, targeted prevention services, early identification and intervention, access to comprehensive treatment, and recovery support services.

The Commission is just beginning to have the resources necessary to support an effective continuum of care with access to treatment as described more than ten years ago in the National Council of State Legislators *Treatment of Alcohol and Other Substance Use Disorders What Legislators Need to Know* guidance documentⁱⁱ:

¹ Established in state statute in 2000 and formerly known as the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment

The word “treatment” may be a misnomer as applied to substance use and addiction because it implies a one-time strategy to eliminate the adverse effects of a physiological condition. Like other chronic and potentially fatal conditions such as heart disease or diabetes, treatment of substance use and addiction actually refers to an extended process of diagnosis, treatment of acute symptoms, identification and management of circumstances that may have promoted the drug use in the first place, and development of life-long strategies to minimize the likelihood of ongoing use and its attendant consequences. In this context, treatment is best viewed as a continuum of different types and intensities of services over a long period of time. A phrase commonly used in the current treatment field is “recovery management,” referring to the structured process of accessing and completing the range of services on the road to health and self-sufficiency. Under the continuum of care model, individuals with alcohol and other substance use disorders move through the spectrum of treatment and other social services. A service network of different programs that provide a multifaceted and multidisciplinary approach is ideal. ... *In fact, measures of success in treatment systems should be based not only reduction or elimination of drug use, but also on the ability of the individual to gain access to and make progress in other types of services (job training, housing, family skills, etc.) to minimize future reliance on public systems.* (italics added for emphasis)

Due to limited resources, the Commission relies on the best available science to inform decisions regarding which practices, programs and policies should be endorsed and funded through the Commission and recommended to member agencies and the Governor.

A LOGICAL APPROACH TO NH ALCOHOL AND DRUG PROBLEMS

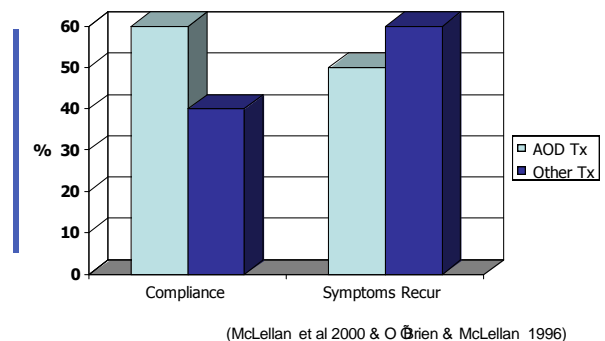


CONSENSUS ON EFFECTIVENESS

Global medical consensus that treatment works is well documented.^{iv} Although addiction is a chronic disease, it can be and is treated successfully. Chronic diseases require treatment throughout an affected person's life. Whether the disease is an alcohol or drug use disorder, diabetes, asthma, or hypertension, a patient's success in treatment depends on a number of factors including support for adherence to what is prescribed: ongoing treatment, medication, and/or behavioral changes.^v

Furthermore, research shows that the recurrence of symptoms is influenced by the severity and duration of one's disorder, underscoring the importance of the Commission's comprehensive planning in support of early identification, comprehensive treatment services, adequate length of stay, and on-going "checkups" as are available for other chronic illnesses.

Addiction is as responsive to treatment as any chronic disease

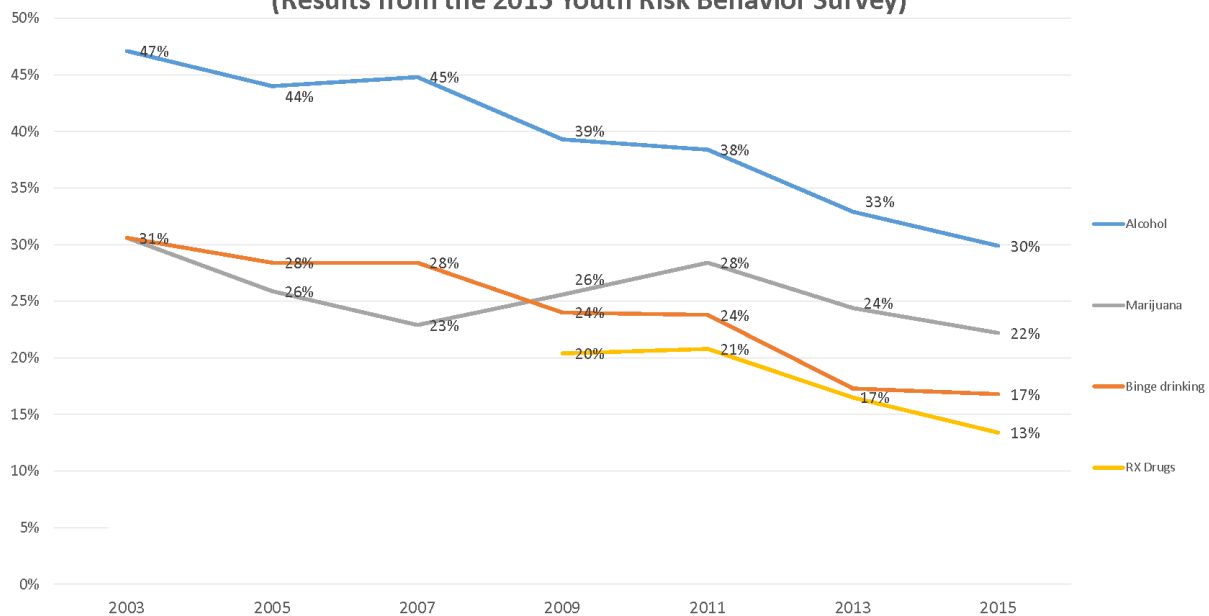


UNDERSTANDING OF COST

A myriad of studies on cost effectiveness reinforce that substance use treatment is both necessary and cost effective, such studies are available for your reference at the end of this document^{vi}. Comparing the cost effectiveness of the level of care of the treatment service or treatment versus prevention is not recommended as that would be equivalent to comparing whether a baby aspirin or bypass surgery is cost effective treatment for heart disease, it depends on the progression, diagnosis, acuity and prognosis of the disorder. The Substance Abuse Policy Research Program concludes that "Extensive research shows there are substantial benefits to treating alcohol and drug disorders. Treatment can lead to reductions in overall health care costs and utilization of health care services"^{vii}.

Following the logic upon which the Commission has built its planning and investments, investing only in activities for which there is evidence of the desired impacts, it is reasonable to expect that transformation to a comprehensive system will have the desired positive effects and that such effects will be evidenced over time. For example, the focus of the regional public health system on alcohol and other drug prevention, through federal block grant funding, has contributed to the impact on youth use trends in a positive direction over time. The 2015 survey results continue to show a trend of reduced underage alcohol use, binge drinking, marijuana use, and prescription drug use over the past 10 years, as investment in evidence informed population strategies are having the predicted impact.

Drug and Alcohol Use among High School Students Declines in 2015
(Results from the 2015 Youth Risk Behavior Survey)



BEST PRACTICE PROMOTION

New Hampshire has invested in a number of best practices across the continuum of care. The following chart and pictograph highlight some of New Hampshire's prominent strategies, the resources acquired to implement these strategies, and their potential reach and impact.

AREA OF FOCUS	STRATEGY	RESOURCES USED TO SUPPORT STRATEGY	MEASURE	PROGRESS
Population-Level	Substance Misuse Prevention (SMP) Coordinators in each region	Federal Block Grant & NH Charitable Foundation funds	Number of Regional SMP Plans	13 3-year plans completed ^{viii}
	Continuum of Care (CoC) Facilitators in each region	Federal Block Grant	Number of Facilitators	13 CoC Facilitators, one in each region
	Anyone.Anytime.NH campaign designed and implemented	Federal Block Grant	Number of Materials Disseminated	8,295 Materials Distributed to NH communities (Pull-Up Banners, Posters, and Rack Cards)
			Paid Media	-Four TV commercials aired 6,344 times -Four radio commercials aired 14,904 times -Eleven newspapers rotated 3

AREA OF FOCUS	STRATEGY	RESOURCES USED TO SUPPORT STRATEGY	MEASURE	PROGRESS
				different ads -122 ATA Mass Transit bus ads -3 malls posted 14 ads
	NH Alcohol and Drug Treatment Locator	Federal Block Grant, Governor's Commission funds & NH Charitable Foundation funds	Number of Sites Listed	Over 300 sites
Prevention	Student Assistance Programs (SAP) in Middle and High Schools	Federal Discretionary Grants	Number of Students Served	8,354 students served in SFY 2015 (Includes total student body as SAP programs serve the entire school)
			Number of Programs	25 programs implemented
	Life of an Athlete (LoA) in Middle and High Schools	Governor's Commission funds	Number of Students Served	3,154 students served
			Number of Programs	84 programs initiated
	Referral, education, assistance and prevention (REAP) for older adults	Federal Block Grant	Number of People Served	3,561 people served
			Number of Programs	10 programs initiated
Early Intervention	Screening Brief Intervention and Referral to Treatment (SBIRT)	NH Charitable Foundation funds for Youth SBIRT Initiative	Number of healthcare settings involved with youth SBIRT initiative	10 organizations with 24 sites planning or implementing SBIRT
		New Hampshire Health Protection Program (NHHPP) & Federal Block Grant for adults and pregnant women	Number of Community Health Centers (CHCs) implementing SBIRT for adults/pregnant women	15 CHCs with 30 sites planning or implementing SBIRT
	Prescription Drug Drop Boxes at Police Departments	Law Enforcement Agency funds	Number of Prescription Drug Drop Boxes	42 collection boxes
	Prescription Medications Collected at Community Take Back Events	Drug Enforcement Administration (DEA) funds	Number of Statewide Take Back Days	10 take back events held as of September 26, 2015
			Amount of Prescription Medications Collected at Take Back Events	50,199.5 pounds of medication collected as of September 26, 2015
Court	Juvenile Court	Governor's Commission	Number of	16 juvenile court diversion

AREA OF FOCUS	STRATEGY	RESOURCES USED TO SUPPORT STRATEGY	MEASURE	PROGRESS
Diversion & Alternative Sentencing	Diversion Programs		Accredited Juvenile Court Diversion Programs	programs
	Drug Courts	Substance Abuse and Mental Health Administration (SAMHSA) or Bureau of Justice Assistance (BJA), county funded, private funding	Number of Drug Courts	5 drug courts
Substance Use Disorder Treatment	Treatment Programs	NHHPP, private insurance, Federal Block Grant, and Governor's Commission funds	Number of Clients Who Received Treatment Services	5,884 clients (2,206 females/3,324 males) received treatment services in SFY 2015 17 and under: 254 (80 females/151 males) 18-24: 1,097 (429 females/588 males) 25-44: 3,357 (1,297 females/1,871 males) 45-64: 1,102 (378 females/662 males) 65 and older: 74 (22 females/52 males)
			Number of Pregnant Women Who Received Treatment Services	76 pregnant women received treatment services in SFY 2015
			Percentage of clients who remained abstinent	91.2% of clients abstinent from alcohol 82.8% of clients are abstinent from Drugs
			Percentage of clients who did not have further involvement with criminal justice system	97.3% of clients had no further involvement with the criminal justice system at discharge
Recovery Support Services	Facilitating Organization, Recovery Centers and reimbursement for services, as well as reimbursement for non-peer Certified Recovery Support Workers (CRSW)	Federal Block Grant, Governor's Commission & NH Charitable Foundation	Funding for peer recovery support services (PRSSs) infrastructure development currently in progress	

Best Practice Promotion

	2011	2012	2013	2014	2015	2016
P		Student Assistance federally funded in 25 schools, 2012			Young Adult Risk Assessment and Prevention Strategies federally funded, 2015 Life of an Athlete adopted by NHIAA and implemented in over 84 programs, 2015	
I	Prescription Medication Community Take Back Events initiated, ten times, 2010-2015	Prescription Medication Community Drop Boxes implemented at at least 42 law enforcement agencies, 2012-2016		SBIRT among youth being planned or implemented across 10 organizations with 24 sites, 2014	SBIRT among adults being planned or implemented across all CHCs, 2015 16 Accredited Juvenile Court Diversion programs, 2015	
T	New WITS data system for treatment programs, 2011	Targeted technical assistance for evidence-based treatment assessments and treatment planning, 2012 & 2013 Clinical Supervision Action Learning Collaboratives facilitated for treatment providers, 2011-2013	Drug Courts in 5 superior courts, 2013	Online directory, NH Alcohol and Drug Treatment Locator created, 2014	Medication Assisted Treatment growing through Block Grant funding and treatment demand, 2015	
R					Federal Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) convened with multiple stakeholders, 2015 Anyone.Anytime. NH Campaign designed and implemented, 2015	Recovery Support Service state funding available to communities, 2016
C				Alcohol and Drug Data Module within WISDOM platform, 2014		

SUMMARY In short, the Commission is maximizing the impact and benefit of available resources through a collective action – collective impact approach driven by evidence informed planning. This transformational approach is increasing the number of NH residents positively impacted and is having a measurable positive impact on residents throughout New Hampshire.

ⁱ http://drugfreenh.org/images/stories/CollectiveAction_Feb2013.pdf

ⁱⁱ Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know. National Conference of State Legislatures. January 2004 <http://www.ncsl.org/print/health/saguidebook.pdf>

^{iv} National Academy of Sciences. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Prepared for the Institute of Medicine by the Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Washington, DC, 2006

^v McLellan *et al.*, "Drug dependence, a chronic medical illness: Implications for treatment," JAMA; Oct 4, 2000; 284, 13

vi National Evaluation Services Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment. The Lewin Group for CSAT, June 2002.

Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know. National Conference of State Legislatures. January 2004 <http://www.ncsl.org/print/health/saguidebook.pdf>

Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011. Published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and the Great Lakes Addiction Technology Transfer Center. March 2012.

http://www.naadac.org/assets/1959/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf

<http://store.samhsa.gov/product/Cost-Offset-of-Treatment-Services-Fact-Sheet-/SMA09-4441>

https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf

The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State. Wicker et al. The Milbank Quarterly, Vol. 84, No. 3, 2006 (pp. 555–576).

Substance Abuse Policy Research Program Policy Brief: Substance Abuse Treatment Benefits and Costs.

http://www.saprp.org/knowledgeassets/knowledge_brief.cfm?KAID=1

- **The economic benefits of treatment exceed the costs of treatment, and the cost-benefit ratio shows that every dollar spent on care results in \$7 dollars in benefits (Ettner et al., 2006; Gerstein et al., 1994; Roebuck et al., 2003; McCollister and French, 2003).**

A study of the economic benefits and costs of treatment for alcohol and drug disorders estimated that the average cost of care was \$1,583 per individual and the economic benefit of care was \$11,487; thus, the benefit to cost ratio exceeded 7:1 (\$11,487/\$1,583) (Ettner et al., 2006). The study used data from the California Treatment Outcome Project (CalTOP) and included 2,567 individuals from 43 treatment programs located in 13 California counties. A similar 7:1 benefit to cost ratio was found when the California Drug and Alcohol Treatment Assessment Program (CalDATA) was examined a decade earlier (Gerstein et al., 1994). Although the studies differed in terms of the time when they were conducted and in terms of the patients used for the study, the similar findings suggest that the 7:1 benefit to cost ratio can be used by policymakers as a reliable estimate.

Economic analyses require detailed estimates of the costs of providing treatment services. A review of cost data from 85 drug abuse treatment programs found that costs varied widely (within and between levels of care) (Roebuck et al., 2003) and the mean costs were higher than the estimated cost in the CalTOP analysis (Ettner et al., 2006). California programs, moreover, tended to have shorter durations of treatment (Ettner et al., 2006). The mean benefit to cost ratio, therefore, may be less than 7:1 when the cost of care is greater. Estimates of total economic benefits include costs associated with increased productivity, reduced criminality, and reductions in medical costs. The most consistent and most substantial economic benefit is the avoided cost of criminal activity (McCollister and French, 2003). It is noteworthy that the increase in wages in the CalTOP study also exceeded the cost of care. Cost avoidance, is therefore not the only source of the economic benefits.

- **Treatment benefits include increases in employment income and decreases in avoided costs of criminal activities, incarceration, and hospitalization (Ettner et al., 2006).**

The economic benefits found in the CalTOP analysis included significant increases in employment income (\$3,352) and significant decreases in avoided costs associated with victimization from criminal activities (-\$3,019), additional costs associated with crimes (-\$2,657), incarceration (-\$1,788), and use of emergency departments (-\$223) (Ettner et al., 2006).

- **Treatment in correctional settings plus aftercare in the community when offenders are released leads to substantial reductions in the rates of re-incarceration and the associated costs of arrest, prosecution, and incarceration (McCollister et al., 2003a, 2003b, 2004).**

Studies in California (McCollister et al., 2003b, 2004) and Delaware (McCollister et al., 2003a) confirm that in-prison treatment combined with continued care in the community following release is the most cost-effective treatment strategy for individuals involved with the criminal justice system. After five years, there was a 13% reduction in days of re-incarceration when inmates who completed an in-prison therapeutic community were compared with inmates who were assigned to a waitlist; the reduction was even more dramatic (45%) if the offenders continued in aftercare when released (McCollister et al., 2003a, 2003b, 2004). Similar results were found when services in Delaware were examined 18 months after program completion (McCollister et al., 2003a).

- **Treatment for alcohol and drug disorders can lead to reductions in the utilization and cost of medical care (Walter et al., 2005).**

Substance abuse treatment for Medicaid patients reduced total medical costs 30% in a comprehensive health maintenance organization (from \$5,402 per treated member in the year prior to treatment to \$3,627 in the following year) (Walter et al., 2005). The reductions, moreover, were in all major areas of health care utilization (hospital stays, emergency visits, and clinic visits) and did not reflect shifts in costs from one area to another (Walter et al., 2005). Washington State integrated addiction treatment databases with Medicaid data and found \$2,500 reductions in annual costs of medical care among General Assistance clients who received substance abuse treatment when compared to those who needed addiction treatment but did not receive treatment (Wickizer et al., 2006).

- **Medicaid patients with histories of alcohol and drug disorders have elevated hospital and psychiatric admissions, and addiction substantially increases total health care costs (Clark et al., 2009).**

Analysis of Medicaid claims data from Arkansas, Colorado, Georgia, Indiana, New Jersey, and Washington compared medical expenditures among individuals with diagnoses of substance use disorders (n = 43,457) to individuals with diagnoses of mental health disorders (n = 105,000). Substance abuse patients had increased treatment for physical health problems in five of six states, and medical expenditures increased significantly with age (Clark et al., 2009).

- **Managed behavioral health care carve-outs appear to reduce the costs of care and support the introduction of parity (Stein et al., 1999; Steenrod et al., 2001).**

An analysis of one employer's claims for substance abuse services following a shift from 23 health maintenance organizations to one managed behavioral health care organization reported significant decreases in the use of inpatient (from 10.6 to 2.5 members per 1,000) and outpatient (45.7 to 12.1 members per 1,000) services and an increase in the use of day hospital and intensive outpatient care (7.7 to 26.7 members per 1,000); a significant reduction in costs was observed in the second year of the carve-out (Stein et al., 1999). These findings appear to replicate across a wide range of studies and settings (Steenrod et al., 2001).

- **Higher insurance co-payments reduce the use of outpatient and inpatient treatment for alcohol and drug disorders (Lo Sasso and Lyons, 2002, 2004; Stein et al., 2000).**

Co-payments for alcohol and drug treatments can inhibit the use of outpatient and inpatient treatment. When co-payments increased from \$10 per outpatient session to \$20 per session, total treatment utilization declined from 5 to 4 outpatient visits (Lo Sasso and Lyons, 2004). Moreover, increased co-payments were associated with higher rates of readmission to treatment, presumably because the prior treatment ended prematurely (Lo Sasso and Lyons, 2002). Similarly, higher co-payments reduced the use of outpatient services following inpatient detoxification (Stein et al., 2000). Strategies that promote aftercare participation for detoxification patients are generally preferred because of the chronic nature of substance use disorders.

- **The loss of insurance benefits is associated with restricted access to care, decrements in beneficiary functioning, and closure of drug abuse treatment centers (Fuller et al., 2006; Deck et al., 2006).**

In 2003, as a response to substantial budget deficits, Oregon's Legislature eliminated Medicaid benefits for recipients of outpatient alcohol, drug, and mental health treatment under the Oregon Health Plan Standard plan. Analyses of the policy change suggest a number of negative consequences.

- Approximately 100,000 women and men lost coverage under the OHP-Standard health plan.
- Impacts were especially apparent among individuals diagnosed with opiate dependence. The probability of admission to a methadone treatment program declined 60% in the year following the elimination of benefits; access was reduced most for homeless, young men, without a history of prior treatment (Deck et al., 2006).
- A prospective assessment suggested that 65% of the 3,000 OHP-Standard beneficiaries enrolled in methadone treatment left care and reported immediate increases in drug use, legal, medical, psychiatric, and employment problems (Fuller, et al., 2006).
- Qualitative interviews with treatment providers found that two methadone clinics were closed and other clinics laid off staff, reduced hours, and reduced health benefits; the net effect was a statewide reduction in access to methadone services for all patients including those with insurance resources or able to self-pay (Deck et al., 2006).
- Outpatient mental health and substance abuse benefits were restored in August 2004. The number of OHP-Standard beneficiaries, however, had declined to about 25,000 and new enrollments were not permitted.
- An analysis of Medicaid expenditures found substantial increase in medical care expenses among individuals who had been receiving substance abuse treatment prior to the elimination of the benefit and implies that elimination of the addiction treatment benefit contributed to the increased medical costs (McConnell et al., 2008).

- **Insurance regulations that deny payment for alcohol-involved trauma care inhibit efforts to identify alcohol problems among patients in emergency settings (Schermer et al., 2003).**

Trauma centers have increased the use of screening tools for alcohol involvement and the use of brief interventions to facilitate entry into treatment (Schermer et al., 2003). Trauma surgeons, however, report a reluctance to screen routinely because insurance regulations in many states permit a denial of claims if alcohol use is implicated in the trauma incident.

- **An evaluation of the introduction of parity for mental health and substance use disorders for federal employees concluded that parity had little impact on total costs (Goldman et al., 2006).**

Seven federal employee health benefit plans were compared to a matched set of health plans that did not have parity for mental health and substance use disorders. A difference-in-difference analysis suggested that increases in utilization of mental health and substance use services was associated with a general cyclical increase in service use rather than an effect of parity; differences between health plans were inconsistent and suggested that parity had little impact on expenditures for mental health and substance abuse treatment (Goldman et al., 2006).

- **Cost-benefit analyses are better than cost-effective analyses in judging economic benefits of substance abuse treatment (Sindelar et al., 2004).**

A methodological analysis of economic studies concludes that cost-benefit analysis is preferable to cost-effectiveness analysis because of the multiple beneficial outcomes associated with treatment for alcohol and drug disorders (Sindelar et al., 2004). Benefit-cost analyses allow the investigators to aggregate benefits across outcome dimensions.

- **A cost-effectiveness analysis of four treatment interventions for adolescents with drug and alcohol problems determined that group therapy was least expensive and most cost-effective but qualified the conclusion because of short follow-up periods and complexities in the comparison of the studies (French et al, 2008)**

The Economic Costs of Substance Abuse Treatment: Updated Estimates and Cost Bands for Program Assessment and Reimbursement. French et al. [J Subst Abuse Treat. 2008 Dec; 35\(4\): 462–469.](#)

vii http://www.saprp.org/knowledgeassets/knowledge_brief

viii <http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm>, 11 of 13 plans posted as of 3/18/16

